TITLE 16

DEPARTMENT OF COMMERCE AND CONSUMER AFFAIRS

CHAPTER 8

PATIENTS' COMPENSATION FUND

Historical Note: Chapter 8 of title 16, Administrative Rules, is based substantially upon Chapter 9, title V, Department of Regulatory Agencies, entitled "Patients' Compensation Fund." [Eff 7/29/77; R 6/22/81]

SUBCHAPTER 1

GENERAL PROVISIONS

§16-8-1 Definitions. Unless the context indicates otherwise, as used in this chapter:

"Claim filed against a health care provider" means any claim arising out of a medical tort which has been received and loss reserve established by the insurer or by a self-insured health care provider.

"Damages" means all damages, including damages for death, resulting from a medical tort.

"Director" means the director of the department of commerce and consumer affairs as defined in section 26-9, HRS.

"Health care provider" means a physician or surgeon licensed under chapter 453, HRS, including one possessing a limited or temporary license, a health care facility and health care service as defined in section 323D-41(4), HRS, and employees of any of them. A "health care facility" or "health care service" includes any program, institution, place, building, or agency, or portion thereof, private or public, other than federal facilities or services, whether organized for profit or not, used, operated, or designed to provide medical diagnosis, treatment, nursing, rehabilitation, preventive care to any person or persons. The terms include health care facilities and health care services commonly referred to as hospitals, extended care and rehabilitation centers, nursing homes, intermediate care facilities, out-patient clinics, ambulatory care facilities, emergency care facilities and center, community mental health and mental retardation centers, home health agencies, health maintenance organizations, blood banks, and others providing similarly organized services regardless of nomenclature.

"Limits of liability per claim" means the maximum liability of the patients' compensation fund for sums which each health care provider shall be legally obligated to pay as ultimate net loss because of all damages resulting from a medical tort.

"Limits of liability per coverage period aggregate" means the total limit of the patient's compensation fund's liability to each health care provider during the coverage period.

"Medical tort" means professional negligence, the rendering of professional services without informed consent as required under section 671-3, HRS, or an

error or omission in professional practice by a health care provider, including, but not limited to, the furnishing or dispensing of drugs or medical or surgical supplies, the handling or performing of autopsies on deceased human bodies, acts or omissions of any individual as a member of a formal accreditation or similar professional board or committee of a health care provider, or as the person charged with the duty of executing directives of any board or committee, which proximately cause death, injury or other damage to a patient. All medical torts in the furnishing of professional services to any person by each health care provider shall be considered one medical tort.

"Per claim" means the maximum amount of the patients' compensation fund's liability for the damages sustained by all claimants as a result of any one medical tort.

"Underlying coverage limit" means the amounts stated in the certificate of participation, which is the liability of the insurer, self-insurer or a cooperative corporation.

"Underlying net loss" means the amount necessary to procure a settlement or satisfaction of the covered person's legal obligation for damages. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-1)

§16-8-2 Requirements to participate in the patients' compensation fund. To participate in the patients' compensation fund, a health care provider shall have basic liability coverage for medical torts in the form of a medical malpractice insurance policy or a self-insurance program approved by the director or participation in a cooperative corporation established under section 435E, HRS. The basic liability coverage shall provide coverage on an occurrence basis in the following minimum amounts:

(1) For individual physicians or surgeons - $200,000 per claim and $400,000 per policy aggregate;

(2) For partnerships or corporations - $200,000 per claim and $400,000 per policy period aggregate for each partner or employee; and

(3) For hospitals and other institutions - $200,000 per claim and $1,000,000 per policy period aggregate.

Basic liability coverage written on a claims made basis shall be acceptable only with the prior approval of the director. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §§671-31, 671-32)

SUBCHAPTER 2

LIMITS OF LIABILITY

§16-8-3 Coverage. The patients' compensation fund shall pay on behalf of a participating health care provider all sums which the health care provider shall become legally obligated to pay as damages as a result of medical torts to the extent that damages exceed the basic liability coverage required to participate in the patients' compensation fund and to the extent of the limit of liability purchased from the patients' compensation fund by the health care provider. Damages as used herein shall not mean or include punitive damages. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §§671-31, 671-32)

§16-8-4 Limits of liability. Eligible physicians, surgeons, hospitals, or other institutions may purchase coverage from the patients' compensation fund in excess of the basic liability coverage in one of the following amounts:

(1) Physicians or surgeons: $800,000 per claim and $2,600,000 per coverage period aggregate ($1,000,000/$3,000,000).

(2) Hospitals and other institutions: $800,000 per claim and $4,000,000 per coverage period aggregate ($1,000,000/$5,000,000).

The figures in parentheses indicate the total per claim and aggregate limit of the basic liability coverage and the patients' compensation fund coverage upon purchase of the respective liability limits from the patients' compensation fund. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §§671-31, 671-36)

§16-8-5 REPEALED [Eff 6/22/81; R 10/1/82]

SUBCHAPTER 3

REQUIREMENTS FOR SELF-INSURANCE

§16-8-6 Qualification for self-insurance. The director shall issue a certificate of self-insurance after it is determined that the applicant is financially sound by reviewing the assets, liabilities, profit and loss records, net worth and past loss experience and the applicant has complied with the following:

(1) Submitted an application to the director on a prescribed form;

(2) Complied with the "net worth" requirement as described in section 16-8-7;

(3) Executed and filed with the director the self-insurance agreement as described in section 16-8-8; and

(4) Provided the necessary security as a self-insurer as described in section 16-8-10. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-7 "Net worth" requirement. To qualify for a certificate of self-insurance, an applicant must have in the applicant's name alone, a net worth in an amount not less than $200,000. "Net worth" means the excess of the value of assets over the sum of liabilities. In determining the net worth necessary to qualify for a certificate of self-insurance, the director shall consider the nature of the applicant's assets, its location, the availability of the assets to satisfy claims, the applicant's contingent liabilities, profit and loss records, past experience of the applicant, and any other matters bearing on the ability of the applicant to satisfy claims. The applicant shall submit to the director such evidence of the applicant's financial condition as the director deems necessary or desirable to verify the net worth and the financial condition of the applicant. A self-insurer shall immediately report to the director any decrease in the net worth amounting to ten per cent or more of the last statement of net worth and any other change in the financial condition which materially affects the self-insurer's ability to fulfill the obligations under the self-insurance agreement. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-8 Agreement. The applicant shall also execute and file with the director, an agreement in a form prescribed by the director, that if certified as a self-insurer, it shall:

(1) Pay on behalf of the self-insurer and the employees all sums which the self-insurer becomes legally obligated to pay as damages for medical torts during the certification period;

(2) In accordance with section 671-5, HRS, report any medical tort claim that has been settled, arbitrated, or adjudicated to final judgment within ten working days following such disposition;

(3) In accordance with section 671-35, HRS, report to the director within ten working days any medical tort claim filed against the health care provider and make supplemental reports as required by the director;

(4) In accordance with section 671-19, HRS, cooperate with the medical claim conciliation panel for the purpose of achieving a prompt, fair and just disposition or settlement of a claim;

(5) Pay to the director the annual surcharge determined by the director pursuant to section 671-31(a)(2), HRS;

(6) Provide for a complete claims service to process and pay claims with reasonable promptness;

(7) Establish and maintain a self-insurance reserve fund meeting the requirements of section 16-8-9 and submit semiannual reports to the director as to its claims experience and reserve during the certification year;

(8) Maintain the net worth at the level set by the director to qualify as a self-insurer and immediately report any change in the net worth or financial condition to the director as required by section 16-8-7; and

(9) Provide such other information to the director as the director deems necessary and permit the director or the director's authorized representative to inspect and examine the records pertaining to the self-insurer's financial condition processing and payment of claims and any other matters pertinent to the administration and enforcement of chapter 671, HRS. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-9 Self-insurance reserve fund. The self-insurance reserve fund of a self-insurer shall provide for payment into the fund as determined to be necessary to support disbursements to cover malpractice losses and those expenses related to malpractice losses. The determination of the amounts and the times at which the payments shall be made into the reserve fund shall be made by an actuary who is a Fellow of the Casualty Actuarial Society, or a person determined by the director to be qualified by background and experience in claims adjusting and loss reserve technique, using methods currently and customarily used by the insurance industry to determine the adequacy of reserves. All moneys for the reserve fund shall be kept in a separate account and shall not be commingled with other moneys of the self-insurer. The self-insurer may invest the moneys held in the reserve in those securities as may be legally purchased for investment by insurers under chapter 431, HRS. Prior to certification or re-certification as a self-insurer, the applicant shall submit a statement to the director setting forth the amounts and schedule of payments to be made to the reserve fund and the basis for the determination. Establishment of the reserve fund may be waived by the director if the self-insurer's "net worth" as described in section 16-8-7 exceeds $3,000,000. The self-insurer whose reserve fund requirement has been waived shall immediately report to the director any decrease in the net worth. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-10 Surety bond, deposit of security. Self-insurers shall be required to:

(1) File with the director and maintain the bond of a surety insurer in a form approved by the director and in a penal sum not less than $25,000 for individual physicians or surgeons and not less than $50,000 for all other self-insured health care providers, enforceable in the name of the "Director of the Department of Commerce and Consumer Affairs, State of Hawaii" which shall not be cancelled without the prior written approval of the director and conditioned upon performance of the health care providers' obligations under the self-insurance agreement; or

(2) Submit to the director a certificate of the State Director of Finance that the applicant has deposited with the director cash or such other securities deemed adequate by the director to secure the performance by the applicant of its obligations under the insurance agreement and provide evidence that there are no unsatisfied judgments against the applicant. The securities shall, prior to issuance of a certificate of self-insurance, be registered in the name of the "Director of the Department of Commerce and Consumer Affairs, State of Hawaii." The cash or market value of the securities deposited shall be in an amount not less than $25,000 for individual physicians or surgeons and not less than $50,000 for all other self-insured health care providers. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-11 Self-insurance management. A self-insured health care provider may utilize an insurance facility designated by the director to adjust medical tort claims, obtain legal assistance, obtain actuarial expertise in the establishment of loss reserves and to carry out the requirements of the self-insurance agreement. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-12 Duration of certification. A certificate of self-insurance is valid for a twelve-month period unless sooner cancelled by the health care provider or revoked by the director. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-13 Revocation of certificate of self-insurance. The director may revoke a certificate of self-insurance for good cause at any time after providing

notice and opportunity for a hearing in accordance with sections 91-9, 91-9.5, 9-10, 9-11, 9-12, and 9-13, HRS. Failure to comply with chapter 671, HRS, or this chapter constitutes cause for revocation. Upon such revocation, the director shall promptly notify the board of medical examiners. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

§16-8-14 Termination of self-insurer status and withdrawal of security deposit. A health care provider who terminates the status as a self-insurer or whose certificate of self-insurance has been revoked, and who obtains a medical malpractice insurance policy may apply to the director for return of the security or cancellation of the bond. The director shall return the security or approve cancellation of the bond only when the requirements of chapter^O671, HRS, have been met, all claims against the self-insurer have been satisfactorily resolved and that adequate and reasonable provisions have been made for the handling of any future claims allegedly arising out of medical tort which occurred during the period of certified self-insurer status. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-36)

SUBCHAPTER 4

PREMIUM SURCHARGE

§16-8-15 Annual surcharge. On September 1 of each year the director shall actuarially determine the surcharge to be levied in terms of a stated percentage of the surcharge base as defined in section 16-8-16. The director shall notify each participating health care provider and insurer of the surcharge percentage and in addition, notify each participating self-insurer of the surcharge base. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-31)

§16-8-16 Surcharge base. (a) For an individual physician or surgeon, the surcharge base shall be the medical malpractice insurance premium charged by the insurer. In the case of a self-insured physician or surgeon, the surcharge base shall be the comparable insurance premium of an insurance policy.

(b) For a partnership or corporation, the surcharge base shall be the medical malpractice insurance premium inclusive of the partnership or corporation surcharge charged by the insurer. In the case of a self-insured partnership or

corporation, the surcharge base shall be the comparable insurance premium inclusive of the partnership or corporation surcharge of an insurance policy.

(c) For a hospital or other similar institution, the surcharge base shall be the insurance premium charged by the insurer. In the case of a self-insured hospital or other similar institution, the surcharge base shall be the comparable insurance premium of an insurance policy. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-31)

§16-8-17 Payment of surcharge. Each participating health care provider shall pay the surcharge as follows:

(1) If insured, to the insurer together with the insurance premium. The insurer in turn shall remit the surcharge collected to the director within thirty days from the time the insurance premium is collected provided that if the insurer is outside the jurisdiction of the State and fails to collect or remit the surcharge to the director, the health care provider shall pay the surcharge to the director within thirty days from the time the insurance premium is due; or

(2) If a self-insurer, to the director at the time the certificate of self-insurance is issued. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-31)

§16-8-18 Refund of surcharge. If a health care provider ceases practice of medicine and surgery in the State and the board of medical examiners places the license on an inactive status, or if the license is revoked or otherwise terminated, upon application of the health care provider, the director shall refund a pro rata share of the surcharge for the year in which the health care provider's license is placed on an inactive status or is revoked or otherwise terminated and for which the health care provider has paid the surcharge. [Eff 6/22/81; am and comp 10/1/82] (Auth: HRS §671-6) (Imp: HRS §671-31)

Amendments to and compilation of chapter 8, title 16, Administrative Rules, on the Summary Page dated August 27, 1982 were adopted on August 27, 1982 following a public hearing on August 24, 1982, after public notice was given in the Honolulu Advertiser, Honolulu Star-Bulletin, The Maui News, The Garden Island News and the Hawaii Tribune-Herald on August 3, 1982.

These amendments to and compilation of the Administrative Rules shall take effect on October 1, 1982, or ten days after filing with the Office of the Lieutenant Governor, whichever date occurs last.

/s/ Mary G.F. Bitterman
MARY G. F. BITTERMAN
Director of Commerce and Consumer Affairs

APPROVED AS TO FORM:

/s/ Ronald Shigekane
Deputy Attorney General

/s/ George R. Ariyoshi
GEORGE R. ARIYOSHI
Governor of Hawaii

Dated September 4, 1982

September 7, 1982
Filed

Rules Amending Title 16, Administrative Rules
August 27, 1982

SUMMARY

1. Title amended.

2. §§16-8-1 to 16-8-4 are amended.

3. §16-8-5 is repealed.

4. §§16-8-6 to 16-8-18 are amended.

5. Chapter 8 is compiled.

Amended & Comp. eff 10-1-82
982-225